EXHIBIT 8

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT OF ANCHORAGE

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STATE OF ALASKA,)

Plaintiff,)

vs.)

ALPHARMA BRANDED PRODUCTS DIVISION,)

INC., et al.,)

Defendants.)

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Case No. 3AN-06-12026 Civil)

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CAPTIONS CONTINUED ON FOLLOWING PAGE

VIDEOTAPED DEPOSITION OF DAVID L. CAMPANA

and STATE OF ALASKA 30(b)(6)

Taken August 19, 2008

Taken by the Defendants at

Captain Cook Hotel, Whitby Room

939 West 5th Avenue

Anchorage, Alaska

Reported by: Mary A. Vavrik, RMR

Page 22

Q. All right. Now, sir, are you currently employed by the agency in Alaska responsible for the administration of the Medicaid program?
A. The Medicaid pharmacy program.
Q. How long have you been employed by the Medicaid pharmacy program?
A. Just a little over 18 years.
Q. You started about 1990, is that right?
A. That's correct.
Q. Have you been continuously employed by the Medicaid pharmacy program throughout those 18 years?
A. Yes.
Q. Does the agency in Alaska that administers Medicaid go by any particular name?
A. Initially we went by the name of Division of Medical Assistance, and that was changed about four years ago to the Division of Health Care Services.
Q. Have you ever been deposed before, sir?
A. Yes.
Q. How many times have you been deposed?

Page 23

A. I believe it's four times.
Q. Do you recall generally what the context was for those depositions?
A. Yes.
Q. Okay. Were any of them personal matters as opposed to work-related?
A. One was a personal matter.
Q. Focusing on the work-related matters, when did those three depositions take place?
A. Approximately 1997 was one. And -- actually, there were two -- two kind of semi-personal and then the others were work-related. So three -- or two that were work-related. One was about 1997, and then another one was last fall.
Q. Just for the record, were there two of them work-related or three?
A. Two were work-related.
Q. And those were the ones in 1997 and then last fall, right?
A. Correct.
Q. What was the deposition in 1997 about, generally speaking?
A. About pricing of pharmaceuticals.
Q. You recall who the plaintiffs and defendants were in that case?
A. Mylan was the defendant.
MR. MANGI: Pardon the interruption. We are still getting a lot of noise on the phone. Let me remind folks to hit mute, please.
BY MR. MANGI:
Q. Mylan was the defendant in '97. Who was the plaintiff, sir?
A. State of -- actually I think it was State of Alaska and other states.
Q. Generally do you have an understanding as to what that case was about --
A. Yes.
Q. -- with pricing?
A. Well, it was about the pharmaceutical manufacturer increased the price of several generic drugs substantially.
Q. When you say they increased the price, which price are you referring to, sir?

Page 24

Page 25

A. I'm referring to the average wholesale price.
Q. Anything else?
A. That was the main part of the suit.
Q. Did you testify individually or as a representative for the State?
A. I testified as a representative of the State.
Q. Do you recall what the resolution was of that litigation?
A. There was a settlement settled out of court.
Q. Were you the only representative for the State to testify in that case, or were there a --
A. I was the only representative.
Q. Were there other State witnesses who testified in their individual capacities?
A. Not that I know of.
Q. Second deposition you mentioned that you did in a work capacity was last fall, so that would be the fall of '07, correct?

Page 90

competition have anything to do with patent protection?
A. Yes.
MR. BURNHAM: Objection, foundation.
BY MR. MANGI:
Q. What is the relationship between those two things?
MR. BURNHAM: Objection, foundation.
THE WITNESS: A brand named drug, when it's an innovator, comes out onto the market and with its patent, there is a certain amount of protection on that patent. When that patent is up, then a generic manufacturer can bring that drug in. And when they bring it in, they bring it in at a discount off of the brand name's selling price.
BY MR. MANGI:
Q. Do you have an understanding as to why they do that?
A. Because of competition.
Q. And when a generic manufacturer is able to enter the market, in other words, when patent

Page 91

protection is expired, is it fair to say, sir, that whoever wants to can enter that market space?
A. Well, what time period are you asking about?
Q. Well, let's talk about today, to begin with.
A. Okay. Today there is a period of exclusivity where it's given to one or two manufacturers that they can produce that drug. And that's about six months.
Q. And that is to provide an incentive for entry into the market, correct, sir?
MR. BURNHAM: Objection, foundation.
THE WITNESS: I don't know that.
BY MR. MANGI:
Q. Fair enough. After that period expires, then any number of generic manufacturers can enter the market space, correct?
A. That's right.
Q. And if you go back further in time, similarly when generics enter the market and more

Page 92

than one enters, and then they start to compete with each other, as well as with the brand manufacturer if they remain in the space, right?
A. Yes.
MR. HENDERSON: Objection.
BY MR. MANGI:
Q. And it's that competition that results in prices going down, right?
MR. BURNHAM: Objection, foundation.
THE WITNESS: That competition should make prices go down.
BY MR. MANGI:
Q. Now, throughout this time period, sir, when you were in pharmacy school right up until 1990, was it generally your understanding that in most cases generic drugs were going to be cheaper than branded drugs?
A. Yes.
Q. Now, they will be cheaper for both a cash paying-customer as well as for a third-party payer, such as a private insurer or a Medicaid entity, correct?

Page 93

A. Yes.
Q. Is it your understanding, sir, that generally payers for drugs prefer the use of generics versus branded drugs when clinically appropriate?
MR. BURNHAM: Objection, foundation.
THE WITNESS: Yes. They try to push the generic drugs.
BY MR. MANGI:
Q. Why is that?
A. Because --
MR. BURNHAM: Same objection.
THE WITNESS: -- of a money saving.
BY MR. MANGI:
Q. Now, we have spoken about benchmark prices. Did you come to an understanding, sir, at any point during this time period, from 1960s right up until 1990, whether the differential between the benchmark price and the actual price being paid by a pharmacy for drugs was greater for generic drugs than it was for branded drugs?
A. Yes, I've come across that information.

Page 94

Q. What is your understanding of what happens in that area?
MR. BURNHAM: During what time period?
BY MR. MANGI:
Q. Let's start with -- well, back up. When you say you have come across that information, when did you first become aware of that phenomenon?
A. I don't remember time period.
Q. Would it be fair to say it's a long time ago?
A. Yeah.
MR. HENDERSON: Objection.
BY MR. MANGI:
Q. In other words, would you say that's -- perhaps bucketed by decades, would it be fair to say that's perhaps sometime in the '60s or the '70s as opposed to the '80s or the '90s?
A. It's hard to say when I became aware of that.
Q. Well, would it be fair to say it was before 1990?

Page 95

A. Yes.
Q. And what generally did you become aware of, sir?
A. That the net cost to the pharmacy for generics that have been out for a long time was very low compared to the benchmark.
Q. And benchmark that we are talking about here, so the record is clear, is AWP, correct?
A. Correct.
Q. So in other words, at some point prior to 1990, you became aware that when generics come into the market, there is increased competition, correct?
MR. BURNHAM: Objection, foundation.
THE WITNESS: There is increased competition the longer the generic is available.
BY MR. MANGI:
Q. And one manner in which that increased competition manifests itself in the market is increasing discounts, correct?
MR. BURNHAM: Objection, foundation.
THE WITNESS: Yes.

Page 96

BY MR. MANGI:
Q. In other words, it's price competition between the different manufacturers of the generic product?
A. Yes.
Q. And as a result of that price competition, there becomes a greater differential between that benchmark AWP and the actual price that pharmacies are paying than exists for branded drugs, correct?
MR. HENDERSON: Objection.
THE WITNESS: Yes, there is a greater differential.
BY MR. MANGI:
Q. And indeed, the extent of that differential will depend on the number of generics and the extent of competition, correct?
MR. HENDERSON: Objection.
THE WITNESS: The number of manufacturers making that drug.
BY MR. MANGI:
Q. Absolutely. And to put it another way,

Page 97

then, if there is just one generic manufacturer that's in the market competing only with the manufacturer of the brand, that's a different situation from where, let's say, there are five generic manufacturers all putting the same drug in the marketplace, correct?
A. Correct.
Q. In the latter situation where you have many manufacturers selling what's essentially the same drug, there will be a greater degree of competition because they are all competing with each other for the same market space, correct?
A. Correct.
Q. And in that situation, there will be more discounts and a greater differential between the published AWP and the actual price pharmacies are paying than there would be where there is little competition, correct?
MR. BURNHAM: Objection, foundation.
MR. HENDERSON: Objection.
THE WITNESS: Yes.
BY MR. MANGI:

Page 98

Q. And is it fair to say, sir, that the extent of the differential, therefore, is a product of and a function of marketplace competition?
MR. BURNHAM: Same objection.
THE WITNESS: Yes.
BY MR. MANGI:
Q. Is it fair to say, sir, that there is, therefore, no predictable relationship between the AWP of a generic drug and the actual price that a pharmacy is paying to purchase that generic drug?
MR. BURNHAM: Objection, form.
MR. HENDERSON: Objection.
THE WITNESS: I have never seen a formula to exactly determine that.
BY MR. MANGI:
Q. In other words, you understand that it's just something that's going to vary for generic drugs depending on the extent of competition, correct?
MR. BURNHAM: Objection.

Page 99

THE WITNESS: Yes.
BY MR. MANGI:
Q. And you have understood that going back a number of years. You are not sure when exactly, but certainly since before 1990 you have had that understanding, correct?
A. Yes.
Q. Now, are you familiar, sir, with -- withdraw that. Let's turn to the area of branded drugs now and focus on that for a moment. As you have testified this morning, sir, AWP has played different roles in the marketplace at different times, correct?
MR. BURNHAM: Objection, foundation, misstates his testimony.
BY MR. MANGI:
Q. Let me clarify the question. When you first came into the pharmacy area, indeed when you were in pharmacy school, one function that AWP served was as a benchmark or a starting price from which discounts were applied to get to the actual price that a pharmacy would pay to

Page 100

purchase drugs, correct?
A. Yes.
MR. BURNHAM: Objection, misstates his testimony.
MR. HENDERSON: Objection.
BY MR. MANGI:
Q. I'm sorry. I didn't hear your answer, sir.
A. Please rephrase the question or ask the question.
Q. Sure. A lot of objections makes it hard to hear. Let's back up.
When you were in pharmacy school, as you have testified this morning, you came to understand that one function that AWP served in the marketplace was to serve as a benchmark price or a starting price from which discounts would be applied to get to the actual price that a pharmacy would pay to purchase a drug, correct?
MR. BURNHAM: Objection, misstates --
MR. HENDERSON: Objection.
MR. BURNHAM: Misstates his testimony.

Page 101

THE WITNESS: The average wholesale was a benchmark and discounts were taken off of that.
BY MR. MANGI:
Q. Then you -- you continued with your career, you came out of pharmacy school, you went to work in a few different pharmacies. And -- sorry. Let me rephrase that question. You then came out of pharmacy school; you went to work in a few different pharmacies in Montana and in Alaska; and you saw that in practice; whereas, you saw that the actual price being paid was different from and lower than the AWP, correct?
A. Yes.
Q. And of course, the degree of information you had about that was different from pharmacy to pharmacy, correct?
A. Yes.
Q. In other words, at Turner Drugs in Montana, you saw the actual invoices. At Pay-N-Save, purchasing was done centrally and you only knew about some of discounts; but generally you understood that that basic fact remained true,

Page 114

the question.
MR. MANGI: Mr. Burnham already objected.
MR. HENDERSON: Okay. Just for the detail, sometimes Mr. Burnham will object on one basis, and I may frequently have an additional basis for an objection. We can either handle that by my making an independent and additional objection, or we can agree that my objection -- that Mr. Burnham's objection encompasses not only the reason that he gives, but any additional reason that I may subsequently choose to give.
MR. MANGI: Well, I can't stipulate to whatever objection may happen to be in your mind somehow being incorporated into what Mr. Burnham says, but if you feel the need to make a particular unique objection, by all means do so.
MR. HENDERSON: I will do so. Thank you.
THE WITNESS: Okay. And your question again about this paragraph?
BY MR. MANGI:

Page 115

Q. So -- and it's just a general question, that we have spoken earlier about a change happening around the late 1980s from the GRM to what we call the Medicaid program. This is the change that you were thinking of, correct?
A. This coincides with the change that I understand and have read about.
Q. Okay. And is it your understanding, sir, that the change that you have read about involved a transition from a system that was purely State funded to a system that involved a share of federal funding?
A. Yes.
Q. Now, this talks about 50 percent federal financial participation. Is it -- do you have an understanding, sir, as to what the share of federal funding was for the program when the -- what we have been calling the Medicaid program was first conceived?
MR. BURNHAM: Objection, foundation.
THE WITNESS: I do not.
BY MR. MANGI:

Page 116

Q. Do you know what that share is today?
A. I don't know the exact number.
Q. Is it in the percentage range of 50 to 60, 60 to 70?
A. It's in the high 50 percent range.
Q. Has it varied over the years?
A. Yes.
Q. Do you have a sense of what the range has been?
A. From 50 to 60 percent.
Q. Now, if we move on to the third paragraph starting in "Currently," the governor talks about currently prescribed drugs being prescribed under the GRM program. He says it's from State money. And then he says "Because federal financial participation for the cost of prescribed drugs is available to the State if it instead offers prescribed drugs through the State Medicaid program, a substantial cost savings to the State will be realized by simply offering prescribed drugs through another assistance mechanism."

Page 117

So he's talking about this is going to save the State money because now the federal government is going to pay a share of the program, correct?
A. Yes.
MR. BURNHAM: Objection, foundation.
BY MR. MANGI:
Q. Now, in the last paragraph, the governor says, "The benefit of this bill is the substantial cost savings to the State with no adverse impact [sic] on needy persons served." Do you have an understanding, sir, as to whether or not that was, in fact, an important policy goal when this transition was made from the GRM to the Medicaid program?
MR. BURNHAM: Objection, foundation.
MR. HENDERSON: Objection, leading.
THE WITNESS: That was a goal of the switchover.
BY MR. MANGI:
Q. And when you say that was a goal, what do you mean?

Page 154

towards betterment of pharmacy and then carry out some continuing education courses.
Q. Are they a trade group?
A. Rather than being a trade group, I would say a professional organization.
Q. Is one of their roles to advocate for the interests of pharmacists in the state?
A. Yes.
Q. Why was it important in the contemplation of the new Medicaid program for a pharmacist to work with that association in relation to ensuring access was maintained?
MR. BURNHAM: Objection, form.
THE WITNESS: Because the association did have some power in the marketplace.
BY MR. MANGI:
Q. What do you mean by that?
A. That most of the retail pharmacists in the state belonged to that.
Q. In other words, if they -- the association could serve as a -- a -- a contact point for many different pharmacists, is that

Page 155

correct?
A. Yes.
Q. And they wanted to have a pharmacist for the program interact with that association to ensure that pharmacists would continue to participate in the new Medicaid program, correct?
MR. BURNHAM: Objection.
MR. HENDERSON: Objection, form.
MR. BURNHAM: Form.
THE WITNESS: Yes.
BY MR. MANGI:
Q. And did that become eventually, sir, one of the roles entrusted to you once you were hired in 1990?
A. Yes.
Q. Showing you now the next document, sir. This has been marked as Exhibit 5 to your deposition. This is another public document. It's entitled Position Paper, Department of Health and Social Services.
(Exhibit Campana 005 marked.)
BY MR. MANGI:

Page 156

Q. Now, sir, we have spoken about Medical Assistance, and here it's the Department of Health and Social Services. How do these agencies relate to each other?
A. The Division of Medical Assistance is contained in the Department of Health and Social Services.
Q. Have you ever seen this document before?
A. I believe I have seen it before.
Q. Now, I'd like you to turn, please, to the second page of that document. You will see at the top it says, "Basically, four arguments have been made against adding pharmacy services to the Medicaid program." Do you see that, sir? Right at the top of that page.
A. Yes.
Q. Okay. Now, the first argument it lists says, "The Medicaid rules concerning payment for drugs would cause Alaska pharmacies to lose money." And then the response is that "Medicaid rules concerning payment for drugs were amended

Page 157

last October. The new rules offered the State substantial flexibility, including increased freedom from Federal Rules in setting payment rates for drugs." Are you familiar, sir, with the change that's being referred to there?
A. No, I'm not.
Q. But nonetheless, it is your understanding, consistent with what we spoke about this morning, that within the range of reimbursement methodologies that would be acceptable to the federal government, there is a range of discretion left to State Medicaid agencies, right?
MR. BURNHAM: Objection, form.
THE WITNESS: Yes, there is some discretion allowed.
BY MR. MANGI:
Q. And one of the reasons why that discretion is allowed to State agencies is to enable states to take account of local circumstances, correct?
MR. HENDERSON: Objection, form.

Page 158

THE WITNESS: Yes.
BY MR. MANGI:
Q. And those local circumstances could include, for example, what's required to ensure sufficient access to care, right?
A. Yes.
MR. HENDERSON: Objection.
BY MR. MANGI:
Q. Indeed the requirement that a State Medicaid agency provide access to care commensurate with what's available to others in an area, that comes from federal regulation, too, correct?
MR. HENDERSON: Objection, form.
THE WITNESS: It's my understanding that it does.
BY MR. MANGI:
Q. And indeed, another aspect of a local circumstance that a state can take account of and must take account of are the political realities in their area, correct?
MR. BURNHAM: Objection, form.

Page 159

MR. HENDERSON: Objection.
THE WITNESS: I don't know that.
BY MR. MANGI:
Q. Well, let's break it down. One of the functions that the Alaska Pharmacy Association serves is as a lobbying group, correct?
A. Yes.
Q. And there is nothing inappropriate about lobbying; that's just part of our political system, correct?
A. Yes.
Q. And one way in which they are lobbied is by reaching out to legislators and advocating their position to them, correct?
A. Yes.
Q. And of course, some legislators are more receptive to their positions than others, correct?
A. Yes.
Q. And of course, legislators are also part of our political system. They need to be responsive to the needs of their constituents,

Page 160

correct?
A. That's their goal, I believe, to do that.
Q. All right. And again, there is nothing wrong with --
(Interruption in deposition.)
MR. MANGI: I'm sorry. You are dialed into a conference call. Please hang up.
BY MR. MANGI:
Q. And again, there is nothing wrong or inappropriate about that; that's the way our political system is set up, correct?
A. Yes.
Q. Now, certainly pharmacists can often be important constituents for legislators, correct?
A. Yes.
Q. And the pharmacists are respected, often well-known members of their communities, correct?
A. Yes.
Q. And pharmacists in some cases can also be important financial contributors to political

Page 161

campaigns, correct?
MR. HENDERSON: Objection.
THE WITNESS: That's what I believe.
BY MR. MANGI:
Q. So certainly there are some legislators who are active proponents of pharmacists' causes, correct?
MR. HENDERSON: Objection.
MR. BURNHAM: Form.
THE WITNESS: I believe that.
BY MR. MANGI:
Q. Now, if a professional such as yourself working for the Medicaid program wanted at some point to cut reimbursement rates, certainly one of the issues you would be very concerned about is access, right?
A. That's right.
Q. But in addition to that, another part of the reality on the ground that you would need to consider where your proposals have become reality would be whether or not the political capital exists to make such a change, correct?

Page 162

A. Yes.
Q. In other words, you can expect that if you wanted to cut reimbursement rates at any point, you can expect pharmacists would mobilize and advocate against such a cut, correct?
MR. BURNHAM: Objection, form.
THE WITNESS: I believe they would mount some kind of campaign against it.
BY MR. MANGI:
Q. And indeed, that's part of what the pharmacy association's role is, to advocate on behalf of the financial interests of their members, correct?
MR. BURNHAM: Same objection.
THE WITNESS: Yes.
BY MR. MANGI:
Q. Now, certainly in some states pharmacy associations are stronger than in other states, correct?
MR. BURNHAM: Objection, form.
MR. HENDERSON: Objection, foundation.
THE WITNESS: I understand that to be

Page 163

correct.
BY MR. MANGI:
Q. And do you have an understanding, sir, as to whether or not the Alaska Pharmacy Association is an entity that has strong lobbying power in the state of Alaska?
A. It has some lobbying power.
Q. And certainly you would expect them to bring that power to bear if cuts to reimbursement were being contemplated, correct?
A. Yes.
MR. HENDERSON: Objection.
BY MR. MANGI:
Q. So certainly within the realm of deciding what a reimbursement methodology should be in Alaska, like in any other state, one of the realities that professionals such as yourself have to account for are the political realities in the state and whether or not you have the political capital to force through a change you may think appropriate in the face of potential political opposition, correct?

Page 164

MR. BURNHAM: Objection, form.
MR. HENDERSON: Objection, form.
THE WITNESS: There would be opposition. I'd have to work through that.
BY MR. MANGI:
Q. Now, turning back to Exhibit 5, sir, you will see towards the bottom half of that page there is a section B entitled Other Drugs. Do you see that section, sir?
A. Yes.
Q. Now, in the middle of that paragraph there is a sentence starting with "The estimated." It's five lines from the top of that paragraph.
A. I see it.
Q. And it says, "The estimated acquisition costs can be determined through a variety of methods." Now, what is your understanding, sir, of what an estimated acquisition cost is, generally speaking?
A. Estimated acquisition cost is the estimate of acquisition costs from the pharmacies

Page 165

-- or from the wholesaler or the suppliers to the pharmacies.
Q. And I appreciate that's what the term EAC stands for, estimated acquisition cost. Let me focus my question. Is it your understanding, sir, that estimated acquisition cost is a term that comes from regulations regarding the Medicaid program?
A. Yes.
Q. And estimated acquisition cost is a term that's used to refer to the formula that a state uses to reimburse for drugs, correct?
A. Yes.
Q. So if a state is reimbursing at AWP minus X percent, taking into account the access issues, the political constraints, that's referred to as that state's estimated acquisition cost or EAC, correct?
A. Yes.
Q. Now, EAC is not -- it's not the actual price that a pharmacist is paying to purchase a drug, correct?